VIJAYA RADHAKRISHNA, M. D., F. A. A. P.
&
ASSOCIATES

Piscataway, NJ & East Brunswick, NJ

Credit Card Authorization Release Form

Patient (s) Name:____

I,___________________________________, authorize Dr. Vijaya Radhakrishna & Associates to collect any payments required with the credit card account number identified below, which will be kept on file for future use.

____
Signature

____
Print Name

____
Date

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Credit Card Information (Circle One): **VISA** **Mastercard** **Discover** **AmericanExpress**

Name as Printed on the Credit Card: ____

Credit Card Account #: ________________________________ Exp Date: ______________

*CARDHOLDER INFORMATION *

Billing Address: ____

City: ________________________________State _____Zip ________

Phone: ___________________________

Email: ___________________________
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